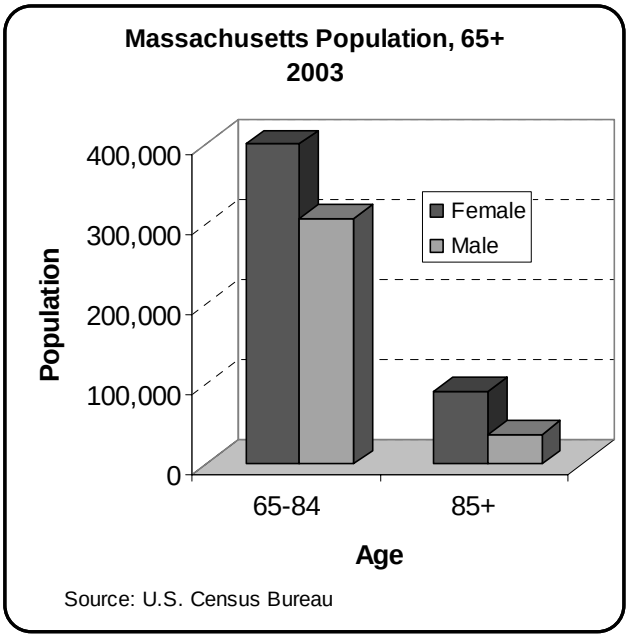
I. Protecting the Well-being of Older Women

Because of demographics, publicly-funded services for elders disproportionately affect women. In 2003 the U.S. Census Bureau estimated 13 percent of the Commonwealth's population was 65 years of age or over. However, a striking characteristic of the population is that the ratio of men to women changes dramatically as the population ages. Of the Massachusetts population age 65 and over in 2003, close to 60 percent were women, but of the population 85 and above, 71 percent were women (see Figure 54).[1]

Figure 54



Poverty among the elderly is also disproportionately concentrated among women. According to figures from the U.S. Census Bureau, approximately 9.4 percent of the Commonwealth's elders age 65 and above live below the official poverty threshold. Of these 75,000 persons, more than 53,000 – or 71 percent – are women.[2]

The average older woman lives six years longer than the average man, and is therefore likely to be widowed and living alone. In Massachusetts, 37 percent of women age 65 and over live alone, compared to 18 percent of men.[3] More than half of the Commonwealth's women 65 and over are separated or have been divorced or widowed.[4]

Older women living alone are particularly vulnerable to poverty. Data from the 2003 Census Bureau estimates indicate that approximately eleven percent of women 65 and over in Massachusetts live below the poverty level, compared to approximately seven percent of men.[5] According to research conducted by the Massachusetts Institute for a New Commonwealth (MassINC), "of all the factors associated with poverty in old age, the most critical is to be a woman without a husband."[6]

There are a variety of factors that lead to this relatively high poverty rate among older single women. Older women are more likely to have had an employment history interrupted by the responsibilities of raising children or caring for other family members. Women are also more likely to have spent some portion of their employment working part-time, and are more likely to have had employment with relatively lower wages. These lower lifetime earnings lead to women's increased economic vulnerability at

retirement. In addition, because women typically rely upon retirement income associated with their spouse's employment, and because women typically outlive their spouses, the financial status of married older women often changes dramatically when their husbands die.

Community-based Elder Care Services

The population of elders living within the community is becoming increasingly frail – both because of the aging of that population, but also because of the extensive network of services available in the Commonwealth that are explicitly designed to allow frailer elders to remain in the community and at home.

Among the elders living in the community, women tend to be frailer than men. According to data from the 2002 Census, in Massachusetts 21 percent of women aged 65 and over living in the community (that is, not in a nursing home or other institution) reported having two or more disabilities. The disabilities included in this survey were sensory disabilities, physical disabilities, mental disabilities, disabilities in self-care, and disabilities that would affect the elder's ability to go outside alone. Only 17 percent of men reported having two or more disabilities.[7]

Almost one-quarter of American households provide care to older friends or relatives, and nearly three-quarters of the caregivers to elders are women.[8] In order to live in the community, elders – particularly those who are frail – draw heavily on support from an informal caregiving network of family and friends. Women are both the primary beneficiaries of these networks and primary caregivers in them. According to a recent study, 28 percent of frail elders drew on spouses for support, 18 percent relied upon a daughter, and 13 percent relied upon a son.[9]

There is a very low rate of women over age 65 without health insurance, because most elders have health insurance through the federally-funded Medicare program. Medicare (Parts A and B) cover hospital inpatient care, as well as outpatient care such as physician care, tests, durable medical equipment, hospice care, skilled nursing care and some home health care. Medicare Part C ("Medicare Advantage") provides for Medicare benefits via private health plans. Medicare Part D – a new prescription drug benefit that will be implemented in 2006 – will provide coverage for some prescription medications.[10] Many elders also purchase private "Medigap" insurance policies to cover some of the areas not covered by Medicare. Medigap policies also typically pay for some of the Medicare deductibles and co-payments.[11]

Although Medicare provides coverage for many acute care health needs, it is not comprehensive. Most significantly, Medicare does not cover what is known as "custodial care," or non-medical long term care. Nationally, approximately 20 percent of women receiving Medicaid are age 65 or older.[12] For low-income elders the Medicaid program

("MassHealth") provides wrap-around coverage for people dually eligible for Medicare and Medicaid, and also is a significant payer for long term care. In 2002, Massachusetts spent approximately $3.64 billion on Medicaid for dually-eligible people. Of that total, $2.49 billion was for the costs associated with long term care. Because of the federal match available for Medicaid services, however, roughly half of this was state dollars.[13]

For very low-income women who are dually eligible for Medicare and Medicaid and whose income is low enough to qualify for federal Supplemental Security Income cash assistance (74 percent of the federal poverty level), Medicaid covers prescription drugs, long term care and home health care, as well as payment for Medicare cost-sharing (premiums and co-payments) and deductibles.

Long term care for elders in Massachusetts is available through a broad continuum of services, paid for through a combination of private resources, and state and federal dollars.[14] When elders have a friend or family member to rely on, they will, and many elders pay privately for long term care. However, when an elder is poor, or without people to rely on, or when the elder becomes increasingly frail, it is often difficult for the elder to coordinate all of the supports that he or she might need to remain in the community. Without appropriate supports in the community, the elder runs the risk of increasing frailty. As one analysis summarized:

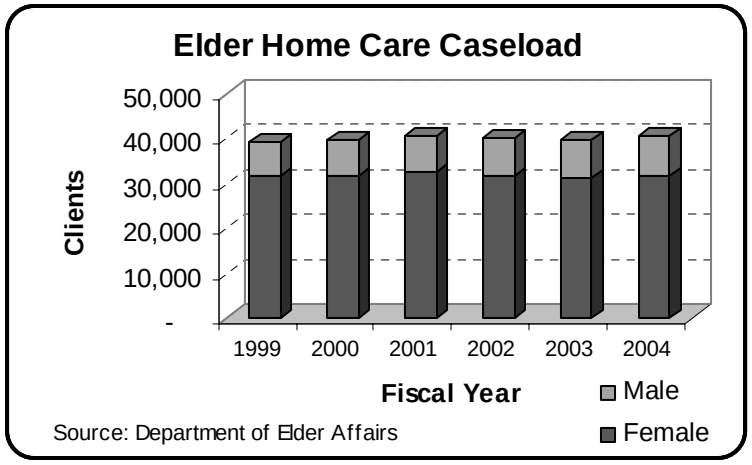
> Institutional care is the only place where there is an established integrated system to pay for elder meals, a bed, chore services, protective services, public safety, medications, mental health supports, medical care, and case management. It is the default locus of care when any gap in services for the poor becomes so great that an illness or significant frailty results.[15]

Nation-wide, more than 80 percent of elders who receive long term care or support live in the community (rather than in a long term care facility.) Massachusetts developed the Elder Home Care program to begin to address some of the needs of elders in the community. Administered by the Executive Office of Elder Affairs through a locally-based network of Aging Services Access Points (ASAPs), the Home Care Program provides a variety of supports to elders who need assistance in daily living skills. The ASAPs also serve the critical function of coordinating care and screening elders for eligibility in the range of programs available. Community supports and services are designed to allow elders to remain independent and in their homes in the community as long as possible. There are also particular programs within the system of services available for elders that provide support to the caregivers of elders in the community.

Eligibility for the state's elder Home Care program rests on three criteria: age, functional need, and finances. Services are available for persons 60 years of age or older, or for persons under the age of 60 with a diagnosis of Alzheimer's disease and in need of respite services. Each applicant is evaluated for level of functioning, based on a number

of activities such as meal preparation, mobility, and ability to dress one's self. Finally, elders must have low or moderate incomes to receive home care services, and for some elders there is a required co-payment. Respite services are available to all eligible elders, based on a sliding fee scale.

Figure 55



The Elder Home Care program is a program largely for women (see Figure 55). Of the 40,000 elders receiving services from the program, between 77 and 80 percent of them are women. Because women are more likely to be the caregivers in a family, an elder male is more likely to have a spouse capable of providing daily care than is a married older woman. Furthermore, since women outlive men, elders living alone and therefore in need of some sort of community-based care are more likely to be women.

In addition to the state-funded Elder Home Care Program, the state has used funding available through a Home- and Community-Based Waiver Program within the Medicaid program to develop an extensive network of services that blend the supports paid for by Medicaid with the state-supported community-based long term care. Among the coordinated models the state has developed is the Community Choices Program which allows for Medicaid coverage of an expanded list of intensive community services elders who would otherwise be eligible for nursing home placement.

Along with Community Choices, the Commonwealth has implemented the federal Program of All-Inclusive Care of Elders (PACE), which provides a comprehensive array of medical and social services to frail nursing home eligible elders. These services – which may be delivered in the home, in an adult day health care setting, or in particular inpatient settings, are coordinated by a team of health professionals from one of six community-based health care facilities. Persons participating in the PACE program receive health care benefits under the MassHealth Standard program.[16]

The Senior Care Options Program, implemented in the spring of 2004, combines Medicare and Medicaid services with social service supports to allow elders to remain in the community. This voluntary managed care program includes coverage of primary and preventive care, inpatient care, community- and institution-based long term care, as well as a variety of other supports.

In addition to these particular programs, there are assisted living facilities, continuing care retirement communities, home health and visiting nursing organizations, and councils on aging – all of which combine to create a broad array of supports that allow the Commonwealth's elders to remain in the community.

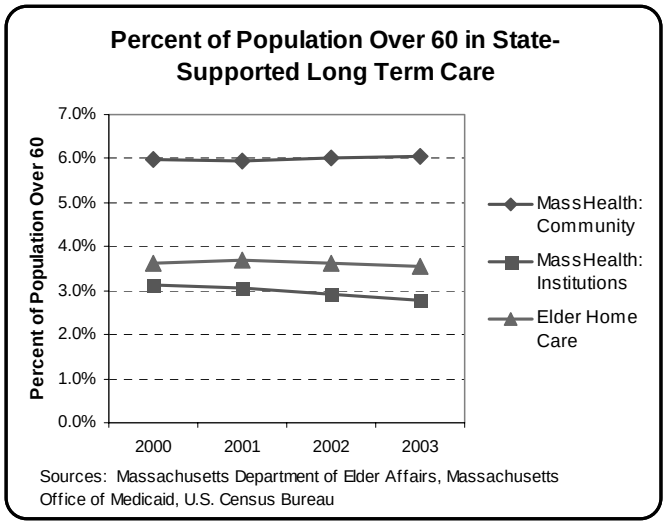
Impact of Changes during the Fiscal Crisis

Because of the complex interplay of state funding for community-based long term care services, and the addition of federal Medicaid dollars to supplement that funding, tracking the direct budgetary impacts of the fiscal crisis on payment for long term care for women in the Commonwealth is problematic. However, there are several points to keep in mind:

- The share of elders in the state's population is growing, and will continue to increase with the aging of the "Baby Boomer" generation.
- The older population is growing increasingly older as life expectancies increase.
- Elders are more likely to be single women, and living in the community, rather than in institution-based long term care facilities.
- Institutional long term care is typically more expensive than community-based long term care, but that difference diminishes as the elders in the community become frailer.

During the fiscal crisis, as Figure 56 indicates, the state's network of long term care supports did not keep pace with the growing demands of an aging population. MassHealth enrollment in the programs for community-based supports for elders, MassHealth enrollment in the programs providing payment for institutionally-based long-term care, and enrollment in the Elder Home Care program all remained relatively flat, or slightly declined as a percentage of the state's population.

Figure 56



Similarly, not only did long term care support for women not keep pace with the growing population, the total number of women receiving MassHealth support for both community-based care and institutional care declined. The number of women receiving MassHealth for institutional care between 2002 and 2004 declined by approximately six percent or close to 1,500 women (from 25,300 to 23,800). This decline was not matched

by an increase in MassHealth support for community care, however, since those programs increased only by just 400 women – an increase of only one percent (from approximately 48,000 to 48,400 women).[17] Between 2002 and 2004, the Elder Home Care Program caseload increased by only ten women.[18]

During the fiscal crisis, the Commonwealth continued its intention to expand the community-based options for frail elders, in order to stave off institutionalization. At the same time, the Commonwealth attempted to ease the costs to the state of Medicaid-funded long term care by tightening eligibility thresholds, proposing increases in asset tests for program eligibility, and changing the rate structure for nursing homes.

For example, in January 2003 the Acting Governor determined that an elder living in the community (the "community spouse") would be able to keep fewer of the joint assets of his or her marriage when his or her spouse applied for MassHealth to pay for the costs of nursing home care. Later that year, new rules required that the spouse living in the community ("the community spouse") would no longer be able to keep some of the nursing home resident's income and all of their joint savings in order to meet his or her personal financial needs. These rules required that the community spouse give up half of his or her jointly-held assets to the nursing home, and their joint income (rather than their assets) would be counted as the primary means of support for the community spouse. Under these rules, if the spouse in the nursing home were to die, the joint income of the surviving "community spouse" would drop, and jointly-held assets would have already been depleted to pay for the costs of qualifying for Medicaid-supported nursing home care. The "community spouse" would be at real risk of impoverishment.[19] These rules were modified again during the course of fiscal year 2005 budget proceedings.

The Commonwealth has also attempted through the budgetary process to expand the ways in which assets are counted for Medicaid-funded long term care as a way to limit access to the program. In fiscal year 2004, the Legislature initially directed MassHealth to seek a federal waiver that would allow Massachusetts to increase the amount of time it could "look back" into an elder's financial transactions to determine whether that elder had improperly disposed of assets presumably to qualify for Medicaid. If a person gives away assets sufficient to qualify for Medicaid asset limitations within 36 months of application for Medicaid, or if a person gives assets to a trust within 60 months of that application, the elder would be deemed ineligible for Medicaid for a certain period of time.[20] Although this proposal has not yet been implemented pending federal approval, it signals the clear intent of the Commonwealth to continue to increase the share of elder's assets used to pay for long term care.

Older women in the Commonwealth are financially vulnerable, and have become more so with the implementation or intended implementation of the kinds of proposals that leave them with fewer and fewer resources to remain independent, financially-solvent, and in the community. With continued attempts to encourage the use of federally-funded

Medicare-supported home health care, and shifting more of the costs to the income and assets of elders in the community, the state has responded to the fiscal crisis by attempting to limit its share of the rapidly rising costs of long term care.

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[1] Census figures are from the U.S. Bureau of the Census, Table 2: Annual Estimates of the Population by Sex and Age for Massachusetts: April 1, 2000 to July 1, 2003 (SC-EST2003-02-25), available at http://www.census.gov/popest/states/asrh/SC-EST2003-02.html.

[2] "Poverty Status in the Past 12 Months by Sex by Age," Table P114, 2003 American Community Survey Summary Tables, U.S. Census Bureau, http://factfinder.census.gov/serlet/DTTable?_bm=y&context+dt&-ds_name=ACS_2003 available at http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=ACS_2003_EST_G00_&-CONTEXT=dt&-mt_name=ACS_2003_EST_G2000_P114&-tree_id=303&-redoLog=true&-all_geo_types=N&-_caller=geoselect&-geo_id=01000US&-geo_id=04000US25&-format=&-_lang=en.

[3] U.S. Bureau of the Census Bureau, Census 2000, Summary File 1, available at www.census.gov.

[4] See "Massachusetts Community Health Information Profile, Elder Health Report," available at http://masschip.state.ma.us/InstantTopics/three.asp?Rptid=200&Geo+2961&lvl=2.

[5] "Poverty Status in the Past 12 Months by Sex by Age," Table P114, 2003 American Community Survey Summary Tables, U.S. Census Bureau, http://factfinder.census.gov/serlet/DTTable?_bm=y&context+dt&-ds_name=ACS_2003 available at http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=ACS_2003_EST_G00_&-CONTEXT=dt&-mt_name=ACS_2003_EST_G2000_P114&-tree_id=303&-redoLog=true&-all_geo_types=N&-_caller=geoselect&-geo_id=01000US&-geo_id=04000US25&-format=&-_lang=en.

[6] Munnell, A.., Cahill, K., Eschtruth, A., Sass, S., *The Graying of Massachusetts: Aging, the New Rules of Retirement, and the Changing Workforce*, MassINC, June 2004, p. 56.

[7] See www.geront.umb.edu/Demographics/disabilities.htm.

[8] *Faces of Caregiving: 2001 Mother's Day Report,* Older Women's League, p. 3-4, available at www.owl-national.org/owlreports/mothersday2001.pdf.

[9] Babcock, E., and Watt, H., "Keeping Elders Home: New Lessons Learned About Supporting Frail Elders in Our Communities," Massachusetts Health Policy Forum Issue Brief, No. 17, December 2002, p.5, available at http://sihp.brandeis.edu/mhpf/Keep_Elders_Home.pdf.

[10] For a complete description of the implementation of the new Medicare Part D benefit, see Smith, Vernon K., Gifford, Kathleen D., and Kramer, Sandra J., *The New Medicare Prescription Drug Law: Implications for Massachusetts State Health Programs*, Massachusetts Medicaid Policy Institute and the Massachusetts Health Policy Forum, September 2004.

[11] "Massachusetts Bulletin for People with Medicare," Massachusetts Executive Office of Elder Affairs, February 2004.

[12] "Medicaid's Role for Women," Issue Brief, Kaiser Family Foundation, November 2004, available at www.kff.org/womenshealth/7213a.cfm.

[13] "Medicaid Expenditures for Dual Eligibles (Full & Partial by State, 2002)," Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/medicaid/7024.cfm.

[14] For a summary of these programs, see Thomson, Deborah and Ford, John, "Back to the Future: The Future of Long Term Care in Massachusetts," Gerontology Institute, University of Massachusetts Boston.

[15] Babcock, E., and Watt, H., "Keeping Elders Home: New Lessons Learned About Supporting Frail Elders in Our Communities," Massachusetts Health Policy Forum Issue Brief, No. 17, December 2002, p.7, available at http://sihp.brandeis.edu/mhpf/Keep_Elders_Home.pdf.

[16] "Access to Health Care in Massachusetts," Massachusetts Division of Health Care Finance and Policy, May 2004, p. 32.

[17] Membership figures from the Massachusetts Office of Medicaid.

[18] Figures from the Massachusetts Executive Office of Elder Affairs.

[19] See The People's Budget for Fiscal Year 2004, The Massachusetts Human Services Coalition,, p. 155.

[20] Thomson, Deborah and Ford, John, "Back to the Future: The Future of Long Term Care in Massachusetts," Gerontology Institute, University of Massachusetts Boston, p. 19.